Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIDLAND MEMORIAL HOSPITAL
3255 W PIONEER PKWY
ARLINGTON TX 76013

Respondent Name
Dallas National Insurance Co

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-12-1294-01

MFDR Date Received
December 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $3,819.24, minus their payment of $2,174.65 there is still an outstanding balance of $1,644.59."

Amount in Dispute: $1,644.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Requestor failed to timely file this dispute."

Response Submitted by: Lewis & Backhaus PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2010	Outpatient Hospital Services	$1,644.59	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 22, 2011
   - 18 – Duplicate claim/service
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - 96 – Non-covered charge(s)
   - P303 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business

- U301 – This item was previously submitted and reviewed with notification of decision issued to payor, provider.
- U634 – Procedure code not separately payable under Medicare and or Fee Schedule guidelines.
- W1 – Workers Compensation State Fee Schedule Adjustment.
- Z306 – Significant, separately identifiable evaluation and management service by the same Physician on the day of a procedure.
- Z547 – This bill was reviewed in accordance with your Fee for Service contract with Coventry.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is December 28, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 29, 2010. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 10, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.